STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 00 B. WING	09/01/2011

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SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN46342

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F0000	This visit was for the Investigation of Complaint IN00095435. Complaint IN00095435 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F323. Survey dates: August 30, 31, and September 1, 2011 Facility number: 000366 Provider number: 155469 AIM number: 100288900 Survey team: Janelyn Kulik, RN Census bed type: SNF/NF: 116 Total: 116 Census payor type: Medicare: 14 Medicaid: 90 Other: 12 Total: 116 Sample: 12 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Preparation and / or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because the provisions of federal and state laws require it. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation for substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 9/7/11 by Jennie Bartelt, RN.			
F0309 SS=G	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure a resident with a swollen right hip was assessed for pain when the resident grimaced during care. The facility failed to implement interventions to prevent further pain during care, when the resident continued to grimace when the right hip was touched. The resident was subsequently diagnosed with a right hip fracture. The deficient practice affected 1 of 5 residents reviewed with injuries in a sample of 12. (Resident #E) Findings include: The record for Resident #E was reviewed on 8/31/11 at 10:45 a.m. The resident's diagnoses included, but were not limited to, dementia, osteoporosis, and urinary incontinence. A nursing note, dated 7/6/11 at 5:00 p.m., indicated charting for 7/2/11 at 3:30 p.m.: The writer was called to the resident's room per the CNA. The CNA related he noticed scratches to the resident's left hip	F0309	F309 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident E 's pain assessment and plan of care have been updated. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be effected by the same alleged deficient practice. Pain assessments were completed for facility residents. Any resident identified as having pain were reviewed in IDT to ensure pain medication orders are present if warranted, and proper interventions are completed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The nurse who cared for resident E on 7-2-11 was reeducated by the DON on proper assessment, interventions and documentation related pain. Licensed nursing staff and C.N.A.'s have been in	09/21/2011

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	area upon rendering care. The writer noticed the resident scratching the area, the scratches had a scant amount of bleeding. The CNA also related that the resident's right hip looked swollen. The resident was assessed and his right hip appeared slightly swollen. The resident had grimacing to touch. He was unable to perform range of motion due to his contractures. There was no bruising noted to his right hip. Care was rendered to the resident per writer and CNA. The resident was positioned comfortably. A nursing note dated 7/6/11 at 5:00 p.m., indicated for 7/2/11 at 3:40 p.m.: A new order was received to x-ray the resident's right hip and to cleanse the left hip scratches with normal saline, pat dry, apply Bacitracin (topical antibiotic), and cover with a 4 by 4 gauze until healed. A nursing note dated 7/6/11 at 5:00 p.m., indicated for 7/2/11 at 9:00 p.m.: The resident was in bed asleep at this time. The CNA related the resident still appeared to be in pain during care but only when touching his right hip. The staff was to continue to monitor. The Administrator provided a reportable incident with investigation on 8/31/11 for Resident #E. The incident and investigation was reviewed on 8/31/11 at		serviced on pain management including: · Assessment · Verbalizing pain/ facial expressions · Notifying nurse · Notifying physician · Obtaining new orders · Interventions **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The DON/designee will review the 24- hour report and incident reports 5 days a week during clinical meeting to identify any condition changes related to pain. The DON/designee will review the documentation and orders with each condition change in the clinical meeting to identify what residents have been assessed as having pain, if the pain assessment was completed, pain medication orders are present if warranted, and if the nurse's notes indicate pain and proper interventions are completed. DON/designee will present a summary of the audits to the QA committee monthly for six months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly for a minimum of six months and presented quarterly at the QA meeting. Monitoring will be ongoing. **Date by which systemic corrections will be completed:** 9-21-2011 An IDR with MPRO is being requested for this tag. This facility is providing clear evidence	

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	11:15 a.m. A hospital x-ray included in the investigation indicated right femur x-ray dated 7/3/11 at 9:10 a.m. with an impression of "Fracture/dislocation right femur and there is mild comminuted intertrochanteric fracture of the right femur. Shaft of the right femur is displaced superiorly and medially by 3-4 cm (centimeters)." The Medication Administration Record (MAR) for July 2011 was blank. There were no medications listed on the MAR. Review of the July 2011 Physician Order Statement indicated no medications had been ordered for Resident #E. Review of a Quarterly Minimum Data Set Assessment (MDS) dated 6/27/11, indicated the resident was rarely understood and rarely understands. There was no assessment of his long and short term memory and he was severely impaired cognitively, indicating he never or rarely made decisions. He was always incontinent of bowel and bladder. A pain assessment was not completed. Interview with the Director of Nursing on 9/1/11 at 10:40 a.m., indicated no pain medications had been given to the resident on 7/2/11 or 7/3/11.		that the facility did assess for pain and implemented interventions to prevent further pain during care. These interventions are reflective of the same plan of care as the hospital. This facility requests that F309 be deleted.	

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	Interview with the Director of Nursing and the Administrator on 9/1/11 at 11:50 a.m., indicated no pain medications had been given to the resident after the swelling to his right hip was observed and he was grimacing. They further indicated since he was only indicating pain when his hip was touched and then did not show signs of pain, staff had not obtained an order for pain medication for the resident. It was also indicated at this time that the original nursing notes were missing and the nurses had to rewritten the events of the day and this was the reason the the entries being dated 7/6/11 for 7/2/11. This federal tag relates to Complaint IN00095435. 3.1-37(a)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure supervision and the correct method of transfer was used for 2 of 5 residents with injuries in a sample of 12 related to transferring a resident without a mechanical lift and with one assist (Resident #J) and no	F0323	**F-323** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident C is no longer in the facility. No corrective	09/21/2011

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	supervising a resident during care resulting with the resident falling on the floor (Resident #C). Findings include: 1. The record for Resident #C was reviewed on 8/30/11 at 2:58 p.m. The resident's diagnoses included, but were not limited to, advanced dementia, history of falls, anxiety, and persistent mental disorder. A nursing note dated 8/18/11, indicated late entry for 8/11/11 at 1:20 p.m.: "Called to pt (patient) room by CNA. Upon entering room, resident (sic) laying on floor on rt (right) side where she had fallen from bed. CNA holding compress on resident's head where minimal bleeding is on compress. Resident alert & (and) responsive. Appointed staff to call 911 & (and) supervisors enter (sic) room. 02 (oxygen) applied via nasal cannula at 2 liters. Resident moaning softly." Vital signs were blood pressure 138/82, pulse 72, respirations 22, and temperature 97.9. Neurological checks were started on the resident and her grasps were equal. A nursing note dated 8/18/11, indicated late entry for 8/11/11 at 1:30 p.m.: The paramedics entered the room and began immediate care for the resident. The		actions can be made. Resident J is no longer in the facility. No corrective actions can be made. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. Resident care cards were reviewed and updated as warranted. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Resident care cards will be reviewed and updated at minimum on admission, readmission, quarterly with the care plan conference, and with condition changes. In-services held on 9/6/11 and 9/7/11 for nurses and CNAs regarding the following: 1. Supervision and transfers a. Prior to transferring a resident i. Check resident's care card for transfer method ii. Obtain equipment needed for transfer iii. Obtain second staff member if required b. While providing care for a resident in the bed by yourself i. Have all supplies at arms reach prior to starting initial care ii. Turn resident toward you while providing care iii. Obtain second staff member to assist if unable to perform task **How the corrective**	

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	paramedics changed compress. A laceration was noted to extend from the middle of the resident's forehead to the right side of her forehead. Staff was unable to get measurements at this time of the laceration. The resident's Care Card was provided on 8/31/11 at 1:50 p.m. by the Nurse Consultant. The Card indicated the resident was an extensive assist (resident involved in activity, staff provide weight-bearing support) for bed mobility with a one person physical assist. She was totally dependent for grooming and bathing with a one person physical assist. At this time the Nurse Consultant, indicated this was not the original Care Card. This card had been recreated from the Minimum Data set assessment. The original Care Card could not be located. The Quarterly Minimum Data Set Assessment dated 8/10/11, indicated the resident was rarely understood and rarely understands. Her long and short term memory could not be assessed. She was severely impaired cognitively indicating she never or rarely made decisions. She had other behavioral symptoms not directed toward others that occurred daily (such as physical symptoms such as hitting or scratching self, or verbal/vocal symptoms like screaming, disruptive		**action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Restorative nurse/designee will randomly observe 5 residents on receiving care while in bed weekly. Any improper technique will be corrected immediately and 'on the spot' in-service will be done with the appropriate staff member for the non-compliance. Restorative nurse/designee will randomly observe 5 resident transfers weekly on alternating shifts. Any improper procedure will be corrected immediately and 'on the spot' in-service will be done with the appropriate staff member for the non-compliance. Restorative nurse/designee will present a summary of the audits to the QA committee monthly for six months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly for a minimum of six months and presented quarterly at the QA meeting. Monitoring will be ongoing.**Date by which systemic corrections will be completed:** 9-21-2011	

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	sounds). She was an extensive assist indicating the resident was involved in the activity with staff providing weight-bearing support with two plus person assist for transfers. She was totally dependent for personal hygiene bathing with a one person physical assist. A Facility Incident Report Form with investigation was provided by the Administrator on 8/31/11. The incident was reviewed on 8/31/11 at 11:40 a.m. The form indicated the incident occurred on 8/11/11 at 1:20 a.m. The resident involved was Resident #C. The Staff involved was CNA #1. A description of the occurrence "Aide was providing a bed bath for resident (sic). Resident was lying on side and suddenly jerked, aide grabbed resident but resident was soapy and aide was unable to stop her from falling from bed. Witness (sic) fall resulted in a laceration to residents head." The occurrence resolution was "Resident sent to ER (emergency room) for eval (evaluation) and treat (treatment), she was admitted to the hospital. Resident remains in the hospital. The aide was inserviced on personal care skills, also an inservice with direct care staff was completed. Interventions for this resident will be assessed and put in place upon readmission."			

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	An inservice record dated 8/11/11 at 1:40 p.m., indicated a summarized content of inservice: "Turning a (sic) repositioning a resident when in bed a) always turn the resident toward you, b) never turn the resident away from you, c) always have needed supplies in front/at side in close reach, d) never have needed supplies in back of you which may cause you to turn your attention away from the resident." The only participant was CNA #1. Review of a hospital record dated 8/11/11 at 15:27 (3:57 p.m.), indicated a chief complaint as a fall. The resident was sent from the nursing home due to a fall out of bed and laceration to head. There was no known loss of consciousness. The resident was nonverbal and bed ridden and cannot give any history. On physical exam it was noted the resident had a 3-4 cm (centimeter) "Y" shaped laceration to top frontal scalp. She had a laceration repair. The location was the forehead with a laceration length of 4 cm which was repaired with one suture. Interview with CNA #1 on 9/1/11 at 11:25 a.m., indicated he was giving Resident #C a bed bath. He turned her on her side facing away from him. He turned to reach for a brief and she lifted up, jerked, and started sliding out of the bed. He then indicated he tried to grab her but she			

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	slipped out of his hands and he could not catch her. He further indicated he was providing care for the resident by himself. He indicated she needed two people to assist with transfers but she was one assist for care in bed. Interview with CNA #2 on 8/31/11 at 1:00 p.m., indicated Resident #C was a one person assist when care was being provided in bed. Interview with CNA #3 on 8/31/11 at 1:06 p.m., indicated Resident #C was a one person assist when care was being provided in bed. Interview with CNA #4 on 8/31/11 at 1:05 p.m., indicated Resident #C was a two person assist at all times, even for care when she was in bed. Interview with CNA #5 on 8/31/11 at 1:15 p.m., indicated Resident #C was a one person assist when she was in bed unless she was combative then she was a 2 person assist. Interview with CNA #6 on 8/31/11 at 3:30 p.m., indicated the resident was a two person assist for care in bed. Interview with CNA #7 on 8/31/11 at 3:35 p.m., indicated the resident was a two			

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	person assist for care in bed. Interview with the Director of Nursing and the Administrator on 9/1/11 at 11:50 a.m., indicated CNA #1 had been a CNA for many years. He felt very bad over the incident. It was further indicated when some of the seasoned CNAs were trained the facilities used side rails on the beds. They then indicated it was not thought to re-educate staff when side rails were removed. It was then indicated staff had been educated with an inservice on how to care for residents when they are in bed. 2. The record for Resident #J was reviewed on 9/1/11 at 10:00 a.m. The resident's diagnoses included, but were not limited to dementia, osteoarthritis, muscle weakness, anxiety, delusional disorder and osteoporosis. A nursing note dated 6/9/11 at 11:15 a.m., indicated upon repositioning resident the writer observed the resident guarding her left knee. The writer assessed the resident and observed her left knee to be swollen and warm to touch. The physician was notified of the assessment and a new order was received for an x-ray of the left knee. Review of a Facility Incident Report Form provided by the Administrator on 9/1/11 at 10:30 a.m., indicated the date of the			

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	incident was unknown. Resident #J was involved. A description of the occurrence: "During repositioning of resident, nurse observed resident guarding left knee." The occurrence resolution: "Nurse assessed residents left knee and notified MD (physician) of assessment finding. An order was received for x-ray. Results of x-ray revealed suspicious fracture of the medial tibia plateau with no significant displacement. The resident was sent to the ER (emergency room) for eval (evaluation) and treatment. Residents family was notified. Hospital report notes severe osteoporosis and acute joint hemarthrosis. Impression shows slightly impacted bilateral tibia plateau fractures of the left knee. Pain screen and Braden pressure sore (score) risk assessments were updated. Through an investigation, it was observed that the upper joint of the leg rest (sic) on her reclining wheel chair aligned with the fractured area. After restorative evaluation, a Broda style chair was ordered for this resident." A hospital left knee x-ray dated 6/10/11 at 2:33 a.m., indicated an impression of slightly impacted bilateral tibia (bone in lower part of the leg) plateau fractures. Review of an assignment sheet provided with the investigation, indicated CNA #8			

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	worked on 6/9/11 for 7-3 and 3-11. A written interview with CNA #8 dated 6/10/11 at 9:00 a.m., indicated CNA # 8 was assigned to Resident #J. "Employee stated she did not notice anything unusual with resident (sic). Stated she did not put on resident's ted hose or see if the resident had them on. Employee stated she transferred resident to bed about 1:00 p.m. on 6/9/11 by herself by standing and pivoting the resident from the chair to the bed. Employee stated she did not review the care card. Employee stated every time she is assigned to this resident she transfers her by standing her up and pivoting her to bed with one assist. ADON (Assist and Director of Nursing) returned call to employee (CNA #8's name) to let her know she was removed from the schedule (days noted)." Employee was to call and speak with the Administrator for results of the investigation. Review of the resident's Care Card which was provided with the investigation indicated she was a sit to stand lift or a hoyer (mechanical lift) with 2 person assist. An Annual Minimum Data Set Assessment dated 4/18/11, indicated the resident was usually understood and			

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	understands. She scored a 5 on her Brief Interview for Mental Status. A score of 5 indicated severe cognitive impairment. She was totally dependent for transfers requiring two plus person physical assist. Interview with the Administrator and the Director of Nursing on 9/1/11 at 11:50 a.m., indicated CNA #8 had been terminated due to not following the resident's plan of care. The resident was to be transferred by a lift and by two persons. The CNA did not use a lift to transfer the resident and did it alone. This federal tag relates to Complaint IN00095435. 3.1-45(a)(2)			